

Medical Copay / Co-insurance / Out-of-Pocket Costs Comparison Chart Plan Year 2012/2013

Benefit Provision		CMG (HMO)	OAP (PPO)		Choice Fund (HDHP)	
		In-Network Coverage Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Deductible (These work differently for CMG, OAP and HSA Plans. Refer to the Benefits website for more information.)	Single	\$350 Facility Deductible	\$350 Annual Deductible	\$700 (one way accumulation)	\$1,200 (cross accumulation) up to \$500 contribution by Maricopa County to your HSA	
	Family	\$700 Facility Deductible	\$700 Annual Deductible	\$1,400 (one way accumulation)	\$2,400 (cross accumulation) up to \$1,000 contribution by Maricopa County to your HSA	
Standard Percent of Co-insurance		N/A	10%	30% of max reimbursable charge	10%	30% of max reimbursable charge
Out-of-Pocket Maximum (Refer to the Benefits website for more information)	Single	\$1,000	\$2,000	\$4,000	\$2,000 (cross accumulation)	\$2,000 (cross accumulation)
	Family	\$2,000	\$4,000	\$8,000	\$4,000 (cross accumulation)	\$4,000 (cross accumulation)
Pre-existing Condition Limitation		None	If 19 or older, 12 months if treatment was received in prior 90 days. Waived (on month by month basis) with Certificate of Creditable Coverage and for employees & dependents currently covered by a County medical plan for at least 12 months. Certificate of Creditable Coverage must be sent to Cigna by the employee.			
Preventive Care		\$0 (FREE)	\$0 (FREE)	Covered in-network only	\$0 (FREE) no deductible	Covered in-network only
Primary Care Physician Services		\$30	\$40	30% after deductible	10% after deductible	30% after deductible
Convenience Care Clinic Visit		\$20	\$30	30% after deductible	10% after deductible	10% after deductible
Specialty Care Physician Services - CCN/Non-CCN		\$45* / \$70**	\$55* / \$70**	30% after deductible	10% after deductible	30% after deductible
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		\$100/type of scan/day***	\$100/type of scan/day***	30% after deductible ***	10% after deductible	30% after deductible
Allergy Injections - CCN/Non-CCN		\$13* / \$28**	\$18* / \$33**	30% after deductible	10% after deductible	30% after deductible
Independent Lab and X-ray Facility		\$0	\$0	30% after deductible	10% after deductible; \$0, no deductible if	30% after deductible
Inpatient Hospital Facility Services (including delivery)		\$250, after deductible	10%, after deductible, \$1,000/ per admit	30% after deductible	10% after deductible	30% after deductible
Inpatient and Outpatient Professional Services (Surgeon, Radiologist, Anesthesiologist, Pathologist)		\$0	10%, after deductible, (\$1,000/per admit maximum on inpatient)	30% after deductible	10% after deductible	30% after deductible
Outpatient Hospital Facility Services		\$125 after deductible	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Pre- & Post-Natal Exams (after pregnancy has been determined)		\$35*/\$50**, waived after 1st visit	\$40/\$55*/\$70**, waived after 1st visit	30% after deductible	10% after deductible	30% after deductible
Urgent Care (Copay reimbursed if referred directly to Emergency Room)		\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	\$75, waived if admitted to hospital	10% after deductible	10% after deductible
Emergency Room		\$200, waived if admitted	\$200, waived if admitted	\$200, waived if admitted	10% after deductible	10% after deductible
Ambulance		\$0	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Durable Medical Equipment/Medical Supplies No annual limit (copay/co-insurance applies to each item)		\$75 DME; \$0 consumable supplies	10% after deductible	30% after deductible	10% after deductible	30% after deductible
External Prosthetics		\$0	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Chiropractic Services; limited to 24 visits/year (combined in and out-of-network for OAP and Choice Fund)		\$30/visit	\$40	30% after deductible	10% after deductible	30% after deductible
Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy, 60 visits combined/yr. (combined in and out-of-network for OAP and Choice Fund)		\$45**/provider per day	\$55**/provider per day	30% after deductible/provider per day	10% after deductible	30% after deductible
Cardiac Rehab; 36 visits/year (combined in and out-of-network for OAP and Choice Fund)		\$45** per visit	\$55**	30% after deductible	10% after deductible	30% after deductible
Alternative Medicine; 20 visits/year \$60 credit for supplies/products		\$30	\$40	Covered in-network only	10% after deductible	Covered in-network only
Bariatric Surgery (1 year waiting period from initial employment)		\$500 copay; in addition to inpatient Hospital Facility Services	\$500 copay; in addition to inpatient Hospital Facility Services	Covered in-network only	10% after deductible	Covered in-network only

For more detail, review the plan summaries on the Benefits Home Page under the Open Enrollment tab, Medical Section or the Cigna tab, or compare plans on www.mycignaplans.com User ID: MaricopaCounty2012 and Password: cigna.

*You pay lower copays when you use a specialist with the Cigna Care Network (CCN) designation.

**You pay higher copays when you use a specialist without the CCN designation. Not all specialties are included in the CCN. When the specialty is not included in the CCN, the higher Non-CCN copay applies except for therapy & rehabilitation.

***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the the applicable place of service co-insurance & deductible.